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Sussex Partnership NHS
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Complex Health Information Pack

C.H.I.P

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Contents:

- Development of the CHIP – brief summary.
- The CHIP.
- The role of the CHIP coordinator.
- Evaluation/feedback of the CHIP.
- The future.
- Looking at The CHIP/Questions.

Background

A growing awareness, both locally and on a national level, that people with profound disabilities experience an increased risk of poor health outcomes:

- Frequent hospital admissions.
- Poor hospital experiences.
- Poor understanding of health needs.

Supported by evidence such as:

- **How People with LD die, Improving Health and Lives** (LD observatory 2010)
- **Raising Our Sights** (Jim Mansell – DOH 2010)
- **Hospital Liaison Team B&H, annual commissioning report** (Cath Scott 2011)
- **Meeting the Health Needs of PWLD** (RCN 2011)
- **CIPOLD** (University of Bristol – DOH 2013)

In 2012 the Brighton and Hove CLDT reviewed how care could be coordinated more effectively for people with complex health needs.

Piloted the implementation of the Complex Health information Pack (**C.H.I.P**)

Core membership of project group included following members of the CLDT:

- **Speech and Language Therapy**
- **Physiotherapy**
- **Nursing**
- **Service Manager**

Project Worker (funded by LDDF) two days a week for six months – commenced in Autumn 2012.

Broad aims of the project:

- Improve the ability of family carers and paid support staff to meet health care needs and be more alert to early signs of any deterioration in health.
- Avoid misdiagnosis and over/under treatment in the primary health care setting.
- Reduce hospital admission and improve hospital discharge.
- Improve the experience in the primary health care setting.

The Vision of CHIP

To present information that directly guides the delivery of care in a format that is both accessible and useful to that person's needs.

Eligibility Criteria

- People with a severe/profound learning disability and two or more complex health conditions.
    - Complex posture, epilepsy, dysphagia, respiratory difficulties, enduring health condition (e.g. M.S, Parkinson's Disease)

Diagnosis

Non-specific/Severe LD

Retts Syndrome

Anglemans Syndrome

Cerebral Palsy

Health conditions

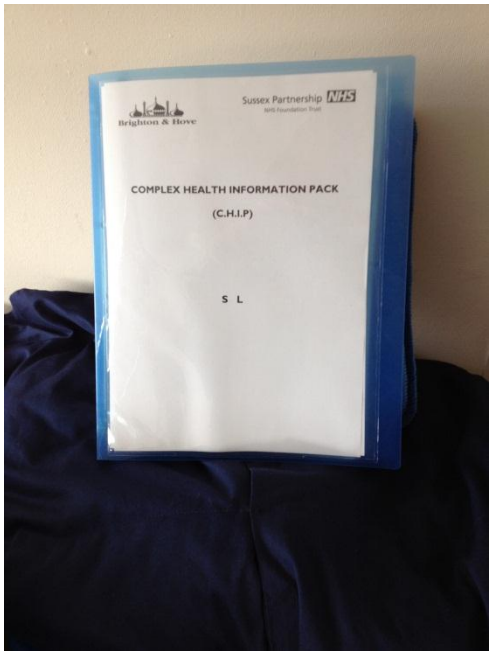
Dysphagia

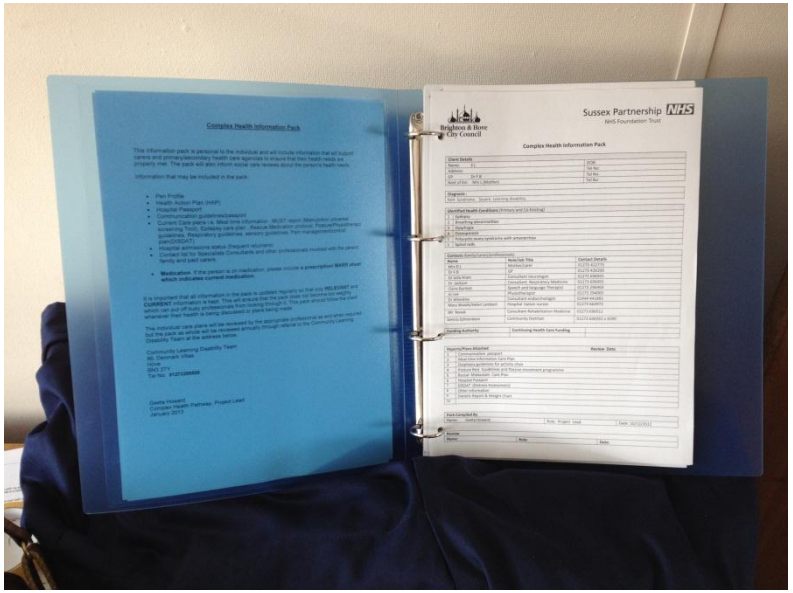
Complex Posture

Epilepsy

MS

Complex Health Information Pack





Complex Health Information Pack

- Each pack is person centred.

- Includes information that will support carers and primary/secondary health care agencies to ensure health needs are properly met – e.g. care guidelines.

- Pack will inform social care reviews about individual's health needs.

- The pack will travel with the person and be used in a variety of settings: i.e. health care appointments, hospital admissions, day service/employment activities, respite services etc.

Standard Information

Front sheet –

- **Client details**
- **Contact details of family/carers, GP and other agencies/professionals involved**
- **Diagnosis. Identified health conditions.**

Pen profile

Mental Capacity Act – brief over view of process.

Top tips on communication (communication passport)

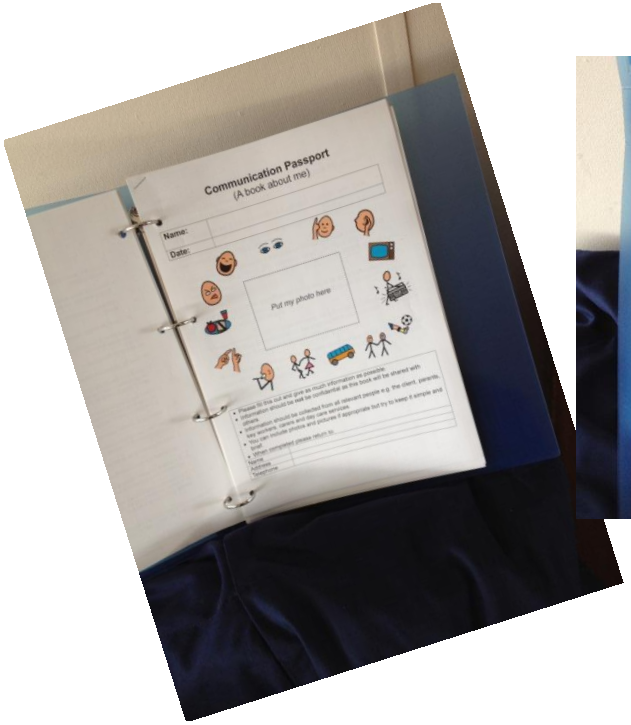
Hospital Passport

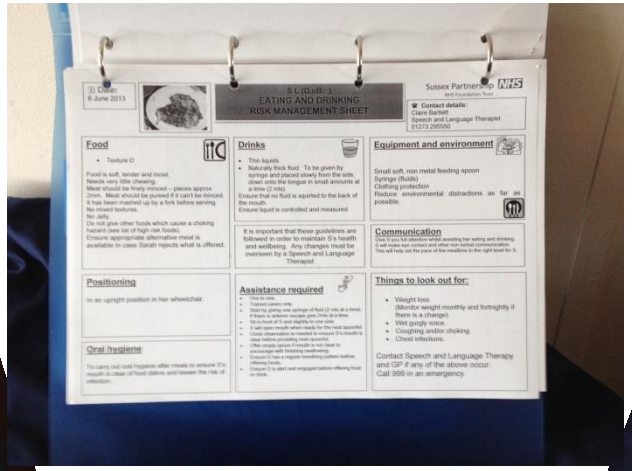
Examples of Care plans

- **Eating and drinking risk management sheets**
- **Epilepsy care plans (rescue medication protocols)**
- **Posture/exercise guidelines**
- **Respiratory care guidelines**
- **Communication guidelines**

Other Information

- **DISDAT – pain management tool.**
- **MUST report - Malnutrition Universal Screening Tool**
- **Information specific to the client's diagnosis**


Communication Passport
(A book about me)
Name:
Date:
Put my photo here


EATING AND DRINKING
RISK MANAGEMENT SHEET
Food
Drinks
Equipment and environment
Communication
Positioning
Assistance required
Things to look out for:
Oral hygiene


My Hospital Passport
Things you must know about me
Things that are important to me
My likes and dislikes

CHIP Co-ordinator – The Role

Leadership – to have over sight of the person's care and be the point of contact for all stakeholders.

Recording – to ensure that the CHIP is up to date and shared with stakeholders. *Clinicians still have responsibility for individual care guidelines.*

Review – to lead person centred reviews and ensure they are undertaken at least yearly.

Support/training – to maximise opportunities for care staff/family carers to undertake training and/or linking with mainstream health services.

Comments from carers/families

- "Well put together"
- "Quick and easy to access information in the pack"
- "Useful at appointments with other professionals/hospital as it provides up to date and correct information about the person"
- "Provides consistency in supporting client as everyone has the same information and working to the same guidelines"
- "Amazing, I will take it to the day centre and share with the staff"
- "The info pack was very good and it was great to have an all-round picture of what 'H' is like and what she needs"

The Future

- **Extending the membership of the steering group to include:**
  - **Hospital liaison team.**
  - **Carer representative**
  - **Advocate**

- **Understanding the impact of coordination upon the CLDT**

Questions

Additional Information

The coordinator is currently allocated from the project group – Nursing, SALT or physiotherapy. This will be extended to all members of those individual disciplines involved in the care of eligible clients.

Role is in addition to individual clinical responsibilities.

Advantages:

- **Reinforces the concept of coordination throughout the team.**
- **Allows for flexibility in the co ordination of cases.**
- **Maximises capacity of coordination by the team.**
- **Ensures sign up to CHIP by the whole team.**

How/When is information Coordinated?

- **Weekly – team referral meetings**
- **Monthly – steering group meetings**
- **6 monthly – clinical reviews**
- **Yearly – social services and CHIP reviews**

Coordinator can also be contacted day to day.

First Evaluation

Initial report by project worker:

Key issues:

• Service users were from a variety of settings – e.g. full time residential care, living with families, accessing respite services

• 14 CHIPS completed

• Identified the need to review some care guidelines

• Actively used on both hospital admission and out patient appointments.

Evaluation and feedback

- Contact list of professionals in the pack particularly useful.

- Identified some training needs of carers.

- Carers more aware of the health needs and what guidelines are in place.

- Assists hospital liaison nurses in meeting needs on admission.

- Assists preparation for attendance to outpatient and inpatient visits.